Medical Care Evaluation Studies

For Utilization Review in Skilled Nursing Facilities

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Medical Care Evaluation Studies

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Introduction

The Utilization Review Committee in a Medicare-approved skilled nursing facility has two basic responsibilities:

1. medical care evaluation review; and
2. extended duration review.

Of the two, medical care evaluation reviews seem to be the most misunderstood and to many the most difficult. Once the purpose of these studies is understood, however, they often become the most beneficial and educational aspect of utilization review.

A medical care evaluation study can be a self-evaluative experience for skilled nursing facility personnel, resulting in improvement in patient care.

Under a contract with the Social Security Administration, the Skilled Nursing Facility Department of the Hospital Utilization Project developed model medical care evaluation studies that can be used as guidelines for skilled nursing facilities in developing studies of their own. The study criteria may be used exactly as presented or altered to satisfy the requirements of the Utilization Review Committee.

In order to insure the relevance of these model studies to the needs of the Utilization Review Committee, they were reviewed and tested by people directly involved with skilled nursing facilities, representatives of State agencies, pharmacists, medical record administrators and intermediaries.

Every conceivable study could not possibly be outlined, but enough examples are presented to help Utilization Review Committees to develop studies of their own.

Methodology

Essentially, a medical care evaluation study involves three steps:

1. Identify a problem area in the facility.
2. Investigate it.
3. Devise a solution.

The utilization review committee must first decide the type of study they would like to do. Their decision could be based on a problem area in the facility (e.g., decubiti), or it could be based on a specific area of interest to the committee (e.g., length of stay for fractured hip patients). The purpose of the study, the population to be studied and the time period would then be decided.

The committee's physicians select the criteria which they feel will best demonstrate the objective of the study. In most cases these criteria, i.e., what the committee wants to know about the patients involved in the study, are abstracted from the patients' medical records.

Data for use in medical care evaluation studies may be compiled either manually by the facility personnel or by use of an external organization such as the Hospital Utilization Project, which compiles statistics and provides comparative data to skilled nursing facilities. In the following model studies, items identified with either an asterisk (*) or a cross (†) can be retrieved by SNF participants through use of the HUP skilled nursing facility data abstract system.

If a computer system is used, the information is transferred to an abstract by a nurse or medical record person. (See Attachment #1 for an example of the HUP/SNF abstract.) The completed abstracts are then tabulated by the external organization and the resulting reports returned to the utilization review committee for review.

If the data is to be extracted manually from patient records, a tally sheet listing all the criteria to be investigated is developed with the approval of the utilization review committee. The information from the patient's medical record is then transferred to the tally sheet. Data from the completed sheets are tabulated and summarized into totals and percentages by medical record personnel, the registered nurse, or capable clerical staff. (See Attachments #3 and #4 for an example of a tally sheet and a report.)

Regardless of the method of study used, the final report must be reviewed and analyzed by the utilization review committee members who then make recommendations regarding solutions to the problem under study. It is then the committee's responsibility to follow up on the recommendations to see that they have been put into effect. Nursing, medical record and administrative staff of the skilled nursing facility may assist in analysis of the study and in making recommendations, depending on the subject being studied.

Finally, the study (or certain portions of it) should be repeated after a few months to determine if the problem situation still exists or if it has been partially or totally eliminated.

Symbols and Abbreviations

The following symbols and abbreviations are used throughout this publication:

*	Information is obtained from the basic HUP/SNF abstract.
†	Information is obtained by using the Special Report Section of the HUP/SNF abstract.
ASHD	Arteriosclerotic Heart Disease
CBC	complete blood count
cm.	centimeter(s)
CVA	Cerebral Vascular Accident
HUP	Hospital Utilization Project
IM	intramuscular
LPN	licensed practical nurse
pt.	patient
resid.	residential
rm.	room
RN	registered nurse
SNF	skilled nursing facility
w/o	without

Medical Care Evaluation Studies

Adequacy of Transfer Information

Purpose

To provide earlier and more rational continuous patient care by having adequate information at the start of care.

Personnel Initiating Study

Medical Director
Administrator
Director of Nursing

Time Period

January 1, 1974 through February 28, 1974. (Two months)

Population

All patients admitted to the facility from a hospital.

Criteria

* **1.** Hospital from which patient was transferred.
† **2.** Referring physician
3. Type of information sent to the S.N.F. by the hospital:
  * **a.** Diagnoses at the time of transfer.
  b. Specific medical information (allergies, etc.).
  c. Diet, drugs and other therapy at the time of discharge.
  d. Physician's orders for immediate treatment.
  e. Relevant patient problems.
† **4.** People in hospital responsible for transfer information.

Findings

1. Hospital X was responsible for the majority of patients without adequate transfer information.
2. Dr. Jones' patients never had adequate transfer information.
3. Patients diagnoses, medications, mental status, histories and physicals were usually omitted on transfer information from hospitals A, B, and X.
4. The medical record administrators and the floor nurses were responsible for sending transfer information from the majority of the hospitals.
5. In all the hospitals, the social workers were responsible for arranging the transfer.

Recommendations of Utilization Review Committee

1. Contact Hospital X's director of nursing to arrange a meeting to discuss information needed to provide continuity of patient care.
2. Have the medical director contact Dr. Jones about information needed to continue patient care at the Skilled Nursing Facility.

3. Investigate using a form to be sent to all hospitals not sending adequate transfer information. The form should contain all information needed by the facilities to provide continued patient care. The hospital would only fill in the blanks. Send the form to the social workers and the medical record administrators.
4. Plan a followup study and discuss results with Hospital X. If there has been no improvement, consider whether the S.N.F. will continue to accept their patients.

Admission Procedure

Purpose

To review and if necessary, improve the patient admission procedures.

Personnel Initiating Study

Medical Director
Administrator
Director of Nursing

Time Period

March, 1974. (One month)

Population

All patients admitted to the S.N.F.

Criteria

1. Basic transfer information received with the patient:
   - * **a.** Diagnoses at time of the transfer.
   - † **b.** Medications, diet and other therapy at the time of discharge.
   - † **c.** Specific medical information (allergies, etc.).
   - † **d.** Physician's order for immediate transfer.

† **2.** Was the admission supervised by a registered nurse?

† **3.** Were history and physical examination available on admission or were arrangements made to have it done by the facility's physician?

† **4.** Was the patient able to answer questions or accompanied by some one able to answer for him?

† **5.** Was the patient given an orientation to his unit?

† **6.** Was the referring physician contacted for standing orders, or was the patient to be transferred to an S.N.F. attending physician?

† **7.** Was there a physician available to order patient medication and diet if the transfer information was inadequate?

† **8.** Were general written orders given to the floor nurse at the time of admission?

† **9.** Were aides familiar with their role in the admission procedure and observation of the patients?

†**10.** Was the patient's skin checked by a registered nurse for decubiti, scars, reddened areas, etc.?

†**11.** Were complete nurse's notes written no later than the end of the shift during which the patient was admitted?

†**12.** Was a pre-assembled chart available?

†**13.** Did the patient unit have the necessary equipment?

†**14.** Was a record kept of the patient's valuables and personal effects (clothing, eyeglasses, dentures, etc.)?

Findings

1. Transfer information was inadequate from hospitals A, B, and C.
2. All admissions were supervised by registered nurses.

3. History and physical examination, CBC, chest x-ray and urinalysis were done within one week from admission if patients were transferred to house staff.
4. If patients maintained the hospital physicians, the hospital histories and physical examinations were used.
5. All patients were required to have someone accompany them on admission.
6. Floor nurses were responsible for orienting the patients to the units.
7. The facility had standing orders on all patients admitted by the house staff.
8. The aides were unfamiliar with their role during admissions.
9. Two nurses checked all patients for decubiti, etc.
10. Nurses notes were written on each shift but were found to be incomplete.
11. Pre-assembled charts were used.
12. The patient units were usually complete.
13. Lists of valuables were kept and signed by the patients or their representatives.

Recommendations of the Utilization Review Committee

1. Contact the directors of the nursing staffs and the directors of the medical record departments of hospitals A, B, and C, to arrange a meeting to discuss information needed to provide continuity of patient care.
2. Develop a written procedure for the Skilled Nursing Facility staff to use regarding admissions.
3. Hold an in-service training program for the staff regarding admissions and recording of admission notes.

Evaluation of Nursing Admission Notes

Purpose

To insure total planning for care by evaluating the patient through a careful inventory of patient resources and problems on admission.

Personnel Initiating Study

Director of Nursing
Physician

Time Period

February 1, 1974 through February 28, 1974. (One month)

Population

All patients admitted to the S.N.F.

Criteria

† **1.** Was admission information collected by licensed practical nurse verified by the registered nurse?
† **2.** Was patient reviewed by a registered nurse on admission?
† **3.** Who wrote nurses' notes? (registered nurse, licensed practical nurse, aide, etc.).
4. Were the following items included in the basic contents of the admission notes?
* **a.** Date of admission.
† **b.** Time of admission.
* **c.** Age.
† **d.** Marital status.
* **e.** Race.
* **f.** Sex.
† **g.** Method/mode of admission and from where.
† **h.** Person accompanying patient.
† **i.** Reason for admission (diagnosis, family problem, etc.)
* **j.** Mobility status.
† **k.** Admitting physician.
* **l.** Physician responsible for care in the S.N.F.
* **m.** Mental status/reaction to admission.
† **n.** Vital signs.
† **o.** "Body Audit". (presence of readily visible birth marks; "ostomy" site; site and size of scars, rashes, bruises, pressure signs, lesions, decubitus, burns, general cleanliness of body, hair, nails, etc.).
† **p.** Permanent physical disabilities (sight, hearing, speech, mobility, paralysis, etc.).
† **q.** Prosthesis needed (glasses, dentures, hearing aid, artificial limbs or eye, etc.).
† **r.** Known allergies.

† **s.** Medication history—is patient presently taking any drugs/ medicine? Did patient bring any medicine to the Skilled Nursing Facility?
† **t.** Eating habits.
† **u.** Sleeping habits.
† **v.** Limited social history (place of birth, level of schooling, previous employment, place of residence at the time of admission, religious affiliation, family ties, hobbies, etc.).
† **w.** Time physician was notified and response.
† **x.** Disposition of personal items accompanying patient.
† **y.** Signature of individual preparing disposition of personal items.

Findings

1. Registered nurses and licensed practical nurses wrote the admission notes.
2. Registered nurses verified all notes written by licensed practical nurses.
3. Most nurses' notes did not say who accompanied the patients.
4. The nurses' notes rarely reflected insight into the patients' psychological reactions to admission.
5. Nurses' notes were consistently inadequate in detailed descriptions of the skin conditions.
6. Special needs of the patients were often omitted.
7. There was no consistency in the contents of the admission notes.
8. The patients' allergies were usually omitted.

Recommendations of the Utilization Review Committee

1. Develop a written procedure detailing the items to be included on nurses' admission notes.
2. Develop a thorough admission form to be used by the nurses.
3. Develop a form which can be used to show a visual body audit (See Attachment #4)
4. Have an in-service training program regarding the importance of concise, relevant nurses' notes and a training session on filling out the admission form.

Completeness of the Patient Care Plan

Purpose

To determine if the patient care plans reflect the patients' needs.

Personnel Initiating Study

Director of Nursing.

Time Period

April 20, 1974. (One day)

Population

10% random sample of all patients in the facility.

Criteria

1. Was the following information included in the patient care plan?
   - † **a.** Patient activities.
   - † **b.** Special needs (side rails, hearing aid, etc.).
   - † **c.** Hygiene (shower, tub, dentures, etc.).
   - † **d.** Diet.
   - † **e.** Feeding problems.
   - † **f.** Fluid needs.
   - * **g.** Bowel and bladder control.
   - † **h.** Allergies.
   - † **i.** Physical traits (blind, right handed, etc.).
   - * **j.** Medications.
   - † **k.** Short term goals.
   - † **l.** Long term goals.
   - † **m.** Patient problems.
   - † **n.** Nursing approaches and solutions to problems.
   - † **o.** Religion.
   - † **p.** Occupation.
   - * **q.** Admission date.
   - * **r.** Diagnosis.
   - * **s.** Physician.
   - * **t.** Age.
   - * **u.** Mental status.

† **2.** Was there a patient care plan?

† **3.** Who initially formulated and updated the patient care plan?

† **4.** Was the information kept up to date?

Findings

1. All registered nurses and licensed practical nurses were responsible for formulating and updating the patient care plans of the patients for whom they provided care.
2. The care plans of ten patients were reviewed. Three of the ten had no care plan.

3. In most cases, the information was not kept up to date. Changes in feeding problems, ambulatory status, and diet were not recorded.
4. Of the basic data to be included in a patient care plan the following information was usually missing:
   a. Patient's special needs.
   b. Long and short term goals.
   c. Nursing approaches and solutions.
   d. Patients' mental status.
   e. Allergies.

Recommendations of the Utilization Review Committee

1. Initiate an in-service training program for all nurses regarding the purpose and importance of patient care plans, which would include:
   a. How to formulate and write complete patient care plans.
   b. Procedures to follow in updating plans:
      (1) Meetings with dietitian, physical therapist, etc.
      (2) Changes in physicians' orders regarding general care, ambulation, medications, etc.
2. Routinely check all patient care plans for completeness every two weeks.

Falls Occurring in the Facility

Purpose

To prevent future falls and to improve the patient care.

Personnel Initiating Study

Medical Director
Director of Nursing
Administrator

Time Period

January 1, 1974 through March 31, 1974. (Three months)

Population

All patients who fell while under care in the facility.

Criteria

† **1.** Date of fall.
† **2.** Time of fall:
  a. Exact time.
  b. Shift.
† **3.** Place of fall:
  a. The specific floor of S.N.F.
  b. Exact location (patient's room, hallway, bathroom, etc.).
* **4.** Ambulatory status of the patient.
* **5.** Mental status of the patient.
† **6.** Were restraints ordered?
† **7.** Number of nursing personnel on unit when fall occurred.
† **8.** Number of patients on unit where fall occurred.
* **9.** Age.
***10.** Primary Diagnosis.
***11.** Patient's attending physician.
***12.** Medications given.
†**13.** Status of floors (slippery, dry, carpeted, etc.).
†**14.** Number of bedridden patients on unit where fall occurred.

Findings

1. Most of the falls occurred in January
2. The majority of falls occurred on 1 Main, usually in the patients' rooms. The patients on 1 Main were generally partial care.
3. The 3:00 p.m.-11:00 p.m. shift had the most falls, between 4:00 p.m. and 6:30 p.m. ("Happy Hour" is between 4:00 p.m. and 5:00 p.m.).
4. The majority of the patients were ambulatory and alert. No restraints were ordered.
5. All the floors were carpeted.
6. All the patients were on tranquilizers.

Recommendations of Utilization Review Committee

1. The medical director should discuss tranquilizer dosage, administration time, and necessity of medication with the physicians.
2. The patients should be checked more carefully on the evening shift for:
   a. Restlessness.
   b. Need to go to the bathroom.
   c. Easy access to the dinner tray.
3. Have an in-service training program for registered nurses, licensed practical nurses and aides on closer observation and care of aged patients.
4. Regulate "Happy Hour" so that the patients on tranquilizers are not also receiving wine.

   (*A Happy Hour is a specific hour during the day when wine is served to patients in the Skilled Nursing Facility.*)

Frequency of Urinary Infections in Patients with Indwelling Catheters

Purpose

To develop more efficient procedures to prevent infections leading to less use of antibiotics and shorter lengths of stay.

Personnel Initiating Study

Director of Nursing
Medical Director

Time Period

November 1, 1973 through January 31, 1974. (Three months)

Population

All patients admitted to facility with an indwelling catheter.
All patients having catheters inserted while in the facility.

Criteria

† **1.** Purpose of catheter and diagnosis.
† **2.** Onset of urinary infection (percent of patients admitted to Skilled Nursing Facility with catheter compared to percent of patients having catheter inserted at the facility).
† **3.** Irrigation procedure/equipment and solution used.
† **4.** Frequency of irrigation.
† **5.** Person irrigating catheter. (R.N., L.P.N., Aide, etc.).
† **6.** Frequency of catheter change/reason.
† **7.** Person inserting catheter/equipment used.
* **8.** Length of stay.
9. Infection ratio of 20% permitted. Over 20% considered by staff as unsatisfactory care.

Findings

1. Urinary tract infections were very frequent, (approximately 50%) whether catheters had been inserted before or after admission to the Skilled Nursing Facility.
2. Most indwelling catheters were inserted prior to S.N.F. admission. The chief reason was incontinence. If no specific urinary problems existed, these catheters were removed at the time of admission.
3. The written irrigation procedure and equipment were satisfactory.
4. Nurses aides were responsible for irrigating catheters. It was felt that perhaps poor techniques were contributing factors to frequent infections, as aides were not using the written procedure.
5. There was no correlation between infection frequency and frequency of catheter change.
6. Patients who had developed infections remained, on the average, ten days longer than those without infections.

Recommendations of the Utilization Review Committee

1. Catheters used for convenience rather than for medical necessity should be removed.
2. Registered nurses or licensed practical nurses should be responsible for all catheter insertions and care.
3. Proper procedures to be followed in all phases of treatment should be written into a manual for use by registered nurses, licensed practical nurses and aides. The procedures should outline:
   a. Insertion of catheter.
   b. Catheter care and maintenance.
   c. Irrigation procedure.
4. An in-service training program should be presented to all nursing personnel to review proper catheter insertion and care, and bowel and bladder training.
5. Bowel and bladder training should be started on an individual basis as soon as possible after patients are admitted. This should be an automatic Skilled Nursing Facility policy, not requiring specific physicians' orders.

Care of Decubiti

Purpose

To provide early care of existing decubiti and to prevent further skin deterioration.

Personnel Initiating Study

Nursing Staff
Medical Director

Time Period

January 1, 1974 through March 31, 1974. (Three months)

Population

All patients admitted to Skilled Nursing Facility with decubiti.

Criteria

* **1.** Age.
* **2.** Mobility status.
† **3.** From where the patient was admitted (hospital, home, etc.)
* **4.** Length of stay in hospital, other facility, or home.
* **5.** Present length of stay in the Skilled Nursing Facility.
* **6.** Mental status.
* **7.** Diagnoses.
† **8.** Location of decubiti.
† **9.** Size and condition of decubiti at the time of admission (from admission notes).
†**10.** Size and condition of decubiti at the time of the study.
†**11.** Specific treatment prescribed for decubiti.
†**12.** Nursing procedures used to prevent further deterioration.
†**13.** General physical condition of the patient.
†**14.** Did a nurse or an aide provide care?
†**15.** How often the patient was turned or moved (as recorded in nurses' notes).
***16.** Bowel and bladder status of the patient.
†**17.** Type of diet.
†**18.** Fluid and food intake.
†**19.** Was the nursing staff aware of the early warning signs of decubiti?

Findings

1. No specific hospital or institution was found to be responsible for patients with decubiti.
2. The lengths of stay in the hospitals were usually long (30 to 45 days).
3. The lengths of stay in the Skilled Nursing Facilities varied.
4. The decubiti occurred mostly on the sacral area, buttocks and heels.
5. The size of decubiti ranged from 2 cm. to 8 cm. in width, and ranged from superficial to 1.5 cm. in depth.
6. Betadine Ointment and prevention therapy was the general treatment for the decubiti.

7. Most patients were either bedfast or in a wheelchair.
8. The mental status of the patients varied.
9. The most common diagnoses were hip fractures and cerebral vascular accidents.
10. The specific treatments for the decubiti varied according to the physicians' orders, the locations, and severities of the ulcers.
11. Physically the patients were in fairly good condition. There were some problems with maintaining the patients' appetites. The diets may have been lacking adequate protein.
12. The patients were occasionally incontinent.
13. General care was provided by aides. It was uncertain if preventative measures were carried out.

Recommendations of the Utilization Review Committee

1. Written procedures should be established regarding routine prevention and care of patients with decubiti.
2. An in-service training program should be presented to staff regarding decubiti care, preventions and early warning signs.
3. The Skilled Nursing Facility should institute routine active and passive exercises.
4. A registered nurse should supervise aides' care at intervals.
5. All patients, especially those with a diagnosis of hip fracture or cerebral vascular accident, should be checked frequently by the nurses for early signs of decubiti.
6. Protection (lambs wool, air cushions, flotation mattresses, etc.) for the patients' heels and bodies should be used when indicated.
7. The patients' positions should be changed frequently, and when possible, they should be encouraged to get out of bed.
8. A proper diet should be encouraged. Some patients may need to be fed.

Unnoted Orders

Purpose

To prevent inadequate patient care due to unnoted orders.

Personnel Initiating Study

Medical Director
Director of Nursing

Time Period

February, 1974. (One month)

Population

All patients in the facility.

Criteria

† **1.** What type of orders went unnoted?
† **2.** Who was responsible for taking orders off the patient's chart?
† **3.** At what time were most of the orders written?
† **4.** What location in the facility had the most problems with unnoted orders?
† **5.** Was there any one physician whose orders were consistently unnoted?
† **6.** Did the facility have a procedure to follow when new orders were written?

Findings

1. Changes in ambulatory status, diet and medications constituted the majority of unnoted orders.
2. The medical secretary or the head nurse were responsible for taking new orders from the patients' charts.
3. Most unnoted orders were written during the 3:00 p.m.-11:00 p.m. shift.
4. There was no specific location in the facility responsible for unnoted orders.
5. Dr. Brown's orders went unnoted most often. (He placed the charts back into the rack after writing them and did not notify the nurses of the new order.)
6. There was no specific procedure followed regarding the taking of orders from the charts.

Recommendations of the Utilization Review Committee

1. Formulate a procedure for registered nurses to follow when new orders are written by physicians.
2. Have an in-service training program on the proper procedures to follow (by both the physicians and the registered nurses) to prevent orders from going unnoted.
3. The medical director should contact Dr. Brown about notifying nurses of new orders.
4. The nurses should routinely check the doctors' order sheets for new orders at the beginning of each shift.

Medication Errors

Purpose

To prevent medication errors by determining the causes.

Personnel Initiating Study

Director of Nursing
Medical Director
Pharmacist

Time Period

January 1, 1974 through March 31, 1974. (Three months)

Population

All patients in the facility involved in medication errors.

Criteria

† **1.** Date of the medication error.
† **2.** Shift and time of occurrence of error.
† **3.** Wing of the facility where error took place.
† **4.** Personnel who made error.
† **5.** What type of error was made (dosage, wrong patient, etc.)
† **6.** Patient's physician.
† **7.** Was there a written procedure for the passing of medication?
† **8.** Which medications were involved?

Findings

1. There were written procedures for preparing and passing oral and IM/subcutaneous medications.
2. The majority of the errors were made by licensed practical nurses; some were made by registered nurses.
3. The types of medications involved were:
   a. Sedatives.
   b. Antibiotics.
   c. Tranquilizers.
4. The errors occurred on all shifts, but the 7:00 a.m.-3:00 p.m. shift was involved most often.
5. The errors usually occurred between 8:00 a.m. and 10:00 a.m.
6. Most of the errors occurred on the ambulatory wings.
7. No specific physician's patients were involved.
8. The types of errors, occurring in the order of frequency, included:
   a. Wrong dosage.
   b. Medications forgotten and not given.
   c. Medications given to the wrong patient.
9. Both oral and IM/subcutaneous medications were involved.

Recommendations of the Utilization Review Committee

1. Have an in-service training program conducted by the director of nursing or in-service coordinator, and the pharmacist, on the preparation and passing of medications. (Special emphasis should be directed towards the 7:00 a.m. to 3:00 p.m. shift personnel and ambulatory wings personnel.)
2. The administrative staff of the facility will investigate using a unit dosage medication system.

Complaints to Nursing Staff or Administration Regarding Patient Care

Purpose

To improve patient care and to promote better family/personnel relationships.

Personnel Initiating Study

Administrator
Director of Nursing

Time Period

January 1, 1974 through January 31, 1974. (One month)

Population

All patients in the Skilled Nursing Facility.

Criteria

1. Type of complaint being made.
2. Who was making the complaint (patient, family, physician, etc.)?
3. Was the complaint investigated? By whom?
4. Was a solution reached? Was it satisfactory to all involved?
5. Specific personnel involved.
6. On what shift was the complaint made?
7. From what floor of the SNF did the complaint come?

Findings

1. The majority of the complaints were made by the patients' families or friends.
2. Generally, the complaints involved patients not being fed, call lights not answered, or bedpans not emptied.
3. Most complaints occurred during the 3:00 p.m.-11:00 p.m. shift, at which time there was one registered nurse and one aide on each floor. Most complaints came from 2 Main.

Recommendations of the Utilization Review Committee

1. Administration should supply complaint forms for patients or relatives.
2. Administration, physician and nursing staff should review specific and recurrent complaints weekly.
3. Additional aides should be added to the 3:00 p.m.-11:00 p.m. shift on 2 Main.

Recreational Therapy

Purpose

To determine if the recreational programs are meeting the needs of the patients.

Personnel Initiating Study

Director of Nursing
Recreational Therapist

Time Period

February, 1974. (One month)

Population

All patients in the facility.

Criteria

* **1.** Age.
* **2.** Diagnoses.
* **3.** Mobility status.
* **4.** Mental status.
† **5.** Type of recreation provided the patient.
* **6.** Length of stay in the Skilled Nursing Facility.
† **7.** Frequency of the patient's recreational activities.
† **8.** Patient's response to the activities.

Findings

1. The patients' ages ranged from 55 years to 99 years.
2. Hip fracture, arteriosclerotic heart disease and cancer were the major diagnoses.
3. The patients' mobility status ranged from bedfast to ambulatory without assistance.
4. Most of the patients were mentally alert but some became confused easily if confronted with an involved activity (bingo, crafts, etc.).
5. Recreational therapy was provided daily in the activities room for all interested ambulatory or wheelchair patients.
6. The activities included crafts (knitting, crocheting, working with shells, decorations, etc.) and bingo every Monday and Wednesday afternoons.
7. There were no daily recreational activities provided to the patients on bedrest, or for those who remained in their rooms.
8. The activities were sporadically attended. Some days only 1 or 2 patients participated.
9. The lengths of stay in the facility ranged from 10 to 40 days.

Recommendations of the Utilization Review Committee

1. Have an in-service training program for the staff on recreational therapy and its value in providing mental stimulation and reality orientation for the patients.
2. The recreational therapists should plan activities on a daily basis and provide a "calendar of activities" each month for the patients.
3. The recreational program should include activities that meet the physical, mental and social needs of the patients (shuffleboard, bowling or miniature golf, travelogs, crafts involving holiday decorations and gifts, card parties, gardening, current events discussions, making dressings for the Cancer Society, group exercises, or games, etc.).
4. The recreational therapist should keep a record of the participation of each patient in the activities provided. Patients not actively participating should be seen by the therapist to determine ways to involve the patients in planned activities.

Lengths of Stay of Fractured Hip Patients

Purpose

To determine if the lengths of stay were appropriate for the types of services provided.

Personnel Initiating Study

Utilization Review Committee

Time Period

January, 1974. (One month)

Population

All discharged patients with a primary diagnosis of fractured hip.

Criteria

* **1.** Specific diagnosis.
* **2.** Physician.
* **3.** Mobility status.
* **4.** Mental status.
* **5.** Number and type of secondary diagnoses.
* **6.** Frequency of physical therapy.
† **7.** Personnel providing care.
* **8.** Length of stay in the Skilled Nursing Facility.
* **9.** Length of stay in the hospital.
***10.** Age.
***11.** Sex.
†**12.** Special needs of the patient.
***13.** Frequency of physician visits.
***14.** Disposition on discharge.

Findings

1. The majority of the patients had a primary diagnosis of Fracture of the Femur with a Smith-Peterson Nail.
2. Drs. Ross and Thomas (orthopedists) were attending physicians for all the patients.
3. The physicians visited weekly but visited more often when necessary.
4. All the patients were weight-bearing and either ambulatory with a walker or able to use a wheelchair.
5. All the patients received physical therapy at least three times a week, some received therapy daily. All showed improvement.
6. Most of the patients were mentally "clear" but some had occasional disorientation.
7. General Arteriosclerosis was the most common secondary diagnosis. One patient also had Parkinson's Disease.
8. Licensed practical nurses and aides provided daily care.

9. Routine daily care was given to the patients. No special services were provided.
10. The average length of stay was 35 days.

Recommendations of the Utilization Review Committee

1. Have an in-service training program, presented by Drs. Ross and Thomas, emphasizing special nursing care of fractured hip patients, to include specialized therapeutic equipment used for these patients.
2. The Utilization Review Committee should review all fractured hip cases staying in the facility over 35 days for the type and appropriateness of services provided, and the need for continued stay.

Deaths Caused by Pneumonia

Purpose

To improve care given in the facility and to prevent deaths caused by pneumonia.

Personnel Initiating Study

Utilization Review Committee

Time Period

September, 1973 through March, 1974. (Seven months)

Population

All patients whose cause of death was listed as pneumonia unrelated to the admitting diagnosis.

Criteria

* **1.** Age.
* **2.** Length of stay in the S.N.F.
* **3.** Primary diagnosis.
* **4.** Secondary diagnoses.
* **5.** Mobility status.
* **6.** Mental status.
† **7.** Patient's location in the S.N.F.
* **8.** Was the patient on inhalation therapy?
† **9.** Could there have been cross-infection from the inhalators?
***10.** Attending physician.
***11.** Frequency of physician visits.
***12.** Medications—type of antibiotic used.
†**13.** How often was the patient turned or moved, as recorded in the nurses' notes?
†**14.** Does an aide or a registered nurse provide most of the care for the patient?
†**15.** Who took care of the patient, and were any of these personnel absent due to illness in a time period related to the onset of the patient's pneumonia?
†**16.** Was a chest x-ray done?
†**17.** What was the general temperature of the room?
†**18.** How many patients were in the room?
19. What was the policy regarding visitors?
†**20.** How much time elapsed between the onset of the fever and notification of the physician?

Findings

1. Ages varied between 65 and 82 years of age.
2. Length of stay varied, but the majority of the patients were in the facility over 21 days.
3. The most common primary diagnosis was hip fracture.
4. The patients usually had secondary diagnoses.

5. The majority of the patients were bedfast.
6. The patients' mental status was usually "clear" or "only occasionally disoriented".
7. There was no specific location in the facility where the deaths caused by pneumonia were occurring.
8. Fifteen percent of the hip fracture patients were receiving inhalation therapy.
9. All inhalators were routinely cleaned between use.
10. The physicians' visits were routinely once a week.
11. There was no policy on how often the patients were to be moved or turned.
12. Twenty percent of the patients were receiving penicillin.
13. Patient care was provided by both RN's and aides.
14. Several of the RN's and aides were absent with flu.
15. Some frequent visitors were also ill.
16. Visitors were not restricted, even if they had previously been ill.
17. A physician was notified if a patient had a fever for over 24 hours.
18. Some rooms had a temperature control that could be regulated by the patients or their visitors.

Recommendations of the Utilization Review Committee

1. Develop a written policy regarding the turning or moving of patients.
2. Present an in-service training program on the care of bedfast patients, prevention of pneumonia, and instruction on breathing exercises.
3. The room temperature control should be regulated by the S.N.F. personnel only.
4. Enforce the policy regarding restriction of visitors during epidemic periods.
5. Get the patients out of bed. Patients may stay in bed only if their temperature is elevated or by order of their physicians.
6. Establish a policy for the nurses to notify the physicians of fevers lasting longer than 2 shifts.
7. Establish a policy that states the attending physician will be routinely asked by mail if he wants to order inhalation therapy for all hip fracture patients admitted to the facility.

Oral Care

Purpose

To include oral care as an integral part of the total patient care for all patients.

Personnel Initiating Study

Director of Nursing
Administrator

Time Period

January, 1974. (One month)

Population

All patients in the facility.

Criteria

† **1.** Was there a written procedure for oral care?
† **2.** Who gave oral care?
† **3.** Was the patient provided with a dental examination?
† **4.** What was the frequency of oral care?
† **5.** What were the patient's special needs regarding oral care?

Findings

1. There were no written procedures regarding oral care.
2. Oral care was provided by registered nurses, licensed practical nurses or aides as part of the daily care. This was rarely mentioned in the nurses' notes.
3. Patient dental examinations were not routine.
4. Approximately 80% of the patients needed help with oral care.
5. The majority of the patients had dentures.
6. Some patients had mouth ulcers or cracked, dry lips and bad mouth odors.

Recommendations of the Utilization Review Committee

1. Develop a written policy regarding proper oral care.
2. Have an in-service training program, directed by a nurse or in-service coordinator and a dentist, regarding correct procedures for and the importance of oral care.
3. Oral care should be provided routinely when daily care is given. Patients who can help themselves and are mentally alert should be provided with toothbrushes, toothpaste, and mouthwash for their use.
4. Arrangements should be made with a local dentist to provide each patient with a dental examination periodically.

Diagnosis And Modified Diets

Purpose
To determine if the diet that the patient is receiving is consistent with his diagnosis or condition.

Personnel Initiating Study
Administrator
Director of Nursing
Consultant Dietitian

Time Period
September, 1975

Population (choose one)
A. All patients on modified diets.
B. 10% of all patients in facility regardless of diet. (Population used for this study.)
C. Review by diagnosis(es).

Criteria
*1. Diagnoses, particularly diabetes and circulatory problems.
†2. The type of diet ordered.
†3. The date the diet was ordered.
†4. How often is the diet reviewed or changed?
†5. Who suggested a modified diet (M.D., family, patient, dietitian, etc.)?
†6. Should the patient's diet be changed?
†7. Should the modified diet have been instituted earlier?

Findings
1. Most of the patients had a diagnosis of cerebralvascular accident or fracture of hip.
2. A general diet was most often ordered regardless of the diagnosis.
3. Most diets were ordered at the time of admission.
4. The diets were never reviewed and rarely changed. They were changed only if there was a complaint from the patient or his family.
5. Modified diets were generally suggested by the physician. Some were suggested by the patient's family.
6. Approximately 40% of the patients reviewed required some kind of diet change. All the changes should have been instituted earlier. For example: There were several patients receiving modifications for congestive heart failure who were not salt restricted, and there were two patients receiving insulin who were not on a diabetic diet.

Recommendations of the Utilization Review Committee
1. All patients should be reviewed by the dietitian at the time of admission for the necessity of a modified diet. She should notify the

physician if she believes that an appropriate modified diet has been omitted.

2. The nurses on each wing should notify the physician if the patient appears to be either dissatisfied or having problems with his meals.
3. Diets should be reviewed monthly by the dietitian for appropriateness. Dietary problems should be communicated to the physician, with suggestions for modification.

Modified Diets Ordered But Not Received

Purpose
To determine if patients for whom modified diets have been ordered are receiving these diets.

Personnel Initiating Study
Administrator
Director of Nursing
Medical Director
Consultant Dietitian

Time Period
October—November, 1975

Population
All patients for whom a modified diet has been ordered.

Criteria
†**1.** Was the ordered modified diet actually being received?
†**2.** When was the modified diet ordered?
†**3.** Was the modified diet ordered at the facility or sent with the patient?
†**4.** What was the date the dietary department received the modified diet order?
†**5.** Was the order verbal or in writing?
   a. Ordered by the physician
   b. Received by the dietary department
†**6.** Is there a policy and a procedure for ordering a modified diet?
   a. Type

Findings
1. 30% of the modified diets ordered were not being received.
2. Most modified diets were ordered at the time of admission. Some patients had diet orders sent with them from the hospital.
3. There was often a lapse of 2 or 3 days before the order was relayed to the dietary department.
4. The order was usually written on the chart by the physician but relayed to the dietary department verbally.
5. There is no standard procedure within the facility for ordering modified diets.

Recommendations of the Utilization Review Committee
1. A written procedure for ordering modified diets should be developed.
2. A list of all patients on modified diets should be kept and checked weekly by the Nutritionist and the Director of Nursing.

3. The Dietary Department should be notified within eight hours of the time the diet order is written by the physician.
4. All dietary orders or changes should be sent to the Dietary Department in writing.

Meals Left Uneaten

Purpose
To prevent nutritional problems in patients who are not eating meals.

Personnel Initiating Study
Administrator
Consultant Dietitian
Director of Nursing
Physician

Time Period
January, 1975

Population
All patients whose meals are usually left uneaten. For this study "uneaten" constitutes less than 50% of the meal eaten. The population could be divided into:

1. Patients confined to their rooms
2. Patients able to go to the dining room

Criteria

1. Patient Needs, Diagnoses, Symptoms
   a. What is the patient's diagnosis?
   b. How frequently are the patients checked to develop a feeding list?
   c. Who checks on the patient?
   d. Is the tray placed conveniently for self-feeding patients?
   e. Does the patient who can feed self need help in preparation to eat?
   f. Does the patient need to be fed? (May be physically but not mentally capable of feeding self.)
2. Delivery of Meals
   a. Are foods served at the intended temperatures? (Hot foods served hot, cold foods served cold?)
   b. How many nursing personnel are on duty during the time meals are served in patient rooms?
   c. What personnel serve the meals?
   d. What is the attitude of the server?
3. Food Preferences
   a. Is the patient's consumption of food largely influenced by food preferences or superstitions?
   b. What type of diet is the patient on?
   c. Have modifications been made to account for food preferences and superstitions?
   d. Which meals are usually left uneaten:
      1. Breakfast
      2. Lunch
      3. Supper

4. Treatment Interference
   a. Does treatment interfere with mealtimes and with food consumption?
   b. Are treatments or therapy which might render the patient overtired or overstimulated given just prior to mealtime?
   c. Do medications given before mealtimes interfere with digestion?
5. Emotional Problems
   a. Is the patient easily upset?
   b. Does the appearance of the food and the tray influence the patient's decision to eat?
   c. Are visitors permitted around mealtime?
   d. Does the patient prefer to talk rather than eat?

Findings

1. The majority of the patients had a diagnosis of cerebrovascular accident or hip fracture (femur); some had carcinoma.
2. The patients were never checked to develop a feeding list.
3. The patient's trays were often placed out of reach of the patient.
4. Approximately 20% of the patients who could feed themselves needed help in setting up the tray or cutting their food.
5. 60% of the patients needed to be fed. Some patients were found to be mentally unable to feed themselves although they were physically capable.
6. 40% stated that the food was cold when they received it.
7. An R.N., an L.P.N., and an aide comprised the nursing personnel on each shift.
8. Approximately 10% of the patients stated that they did not like the food they were being served.
9. Most of the patients were on a general diet. Some were receiving modified diets.
10. General dietary staff, sometimes student help, served the trays.
11. The serving personnel's attitude and appearance varied by individual.
12. Although all meals were involved, the dinner tray was most often left uneaten.
13. Meals are sometimes interrupted by therapy or treatments.
14. Some patients received medications possibly upsetting the digestion prior to meals.
15. Patients were sometimes upset when families visited around meal times.
16. Although some patients were overinclined to talk at mealtimes, it did not appear to affect their eating.

Recommendations of the Utilization Review Committee

1. A routine check of the patients should be made for 2 weeks, daily, by a registered nurse or a licensed practical nurse to develop a list of those patients who need to be fed and those who need help in

setting up the meal. Routinely at regular intervals the patients are to be rechecked to keep the list current. New patients should be added to the listing as appropriate. Nursing personnel should be assigned to assist specific patients at mealtimes.

2. Each room should be checked at meal time to see that the tray is placed so that the patient can comfortably reach it, and whether the patient is being fed or assisted as required. Nursing personnel break times and meal times should be scheduled before or after the patient meals. The administrator and director of nursing should assure that at mealtimes there are adequate numbers of on-duty nursing personnel to assist patients needing help with eating.
3. Whenever possible therapy and treatments should not be scheduled around meal times. Observed needs for modification in treatment, medication and diet should be promptly reported to the director of nursing for referral to the physician, the consultant dietitian and the pharmacist. Patient diets should be reviewed periodically for need of modification by this group.
4. The administrator should investigate the use of hot and cold mobile tables for use in serving patients confined to their rooms. The consultant dietitian and the food supervisor should consider the need for inservice training and tray modifications relating to preparing and serving the tray.
5. Patients should be encouraged to eat in the dining room whenever possible. Visiting hours should be reassessed so that patient routines involving treatments and eating times are not interrupted.

Foot Care

Purpose
To include foot care as an integral part of the total patient care for all patients.

Personnel Initiating Study
Director of Nursing
Physician

Time Period
July, 1975

Population
All patients in the facility.

Criteria
*1. Diagnoses, emphasize especially peripheral vascular disease and diabetes.
*2. Medications
*3. Ambulatory Status
†4. The facility policy regarding foot care.
†5. Who provides daily patient care.
†6. Type of foot care being given.
†7. Frequency of foot care.

Findings
1. The diagnoses varied.
2. Some patients were on anticoagulants.
3. There is no policy regarding routine foot care.
4. L.P.N.'s and Aides provide daily care.
   a. The type of foot care given includes cleaning and drying the feet only.
5. Most of the patients are either wheelchair or ambulatory patients.

Recommendations of the Utilization Review Committee
1. Formulate a written procedure for providing routine foot care.
2. Have an in-service training program given by a chiropodist or a podiatrist on proper foot care.
3. Include foot care as a routine procedure on all patients unless otherwise ordered by the physician. (Patients on anticoagulants, with diabetes, or with peripheral circulatory problems should be given care only under direction of the physician.)

Housekeeping

Purpose
To prevent spread of infection by determining if the procedure used in cleaning and preparing patient rooms for new admissions is satisfactory.

Personnel Initiating Study
Housekeeper
Administrator

Time Period
June, 1975 (one month)

Population
All rooms prepared for new admissions.

Criteria
†**1.** Is there a written procedure for cleaning the patient's rooms?
†**2.** Who cleans and prepares the room?
†**3.** What cleaning solutions and equipment are used?
†**4.** How often is the cleaning equipment changed or cleaned?
†**5.** Are the following areas/items cleaned before each new admission:
- **a.** Floor
- **b.** Overbed table
- **c.** Bedside cabinets
- **d.** Bed frame
- **e.** Mattress
- **f.** Springs
- **g.** Wastebasket

†**6.** Are lotion, soap, kleenex, etc., changed before a new admission?
†**7.** Are new emesis and wash basins, bed pans, urinals supplied before a new admission?
†**9.** If a room is empty for a period of time, is the room cleaned again before an admission?
†**10.** Is any extra cleaning done on rooms where there were known infections?
†**11.** Is the room aired before a new admission?
†**12.** Do infections seem to occur in any one particular room?

Findings
1. There is no written procedure for cleaning patient rooms.
2. The housekeeping staff does the cleaning on the day shift. Nurses cleaned the rooms for new admissions on the evening shift.
3. Soap and water solution is used most often; no germicide is used in cleaning patient rooms.

4. The floor is mopped but the mop is not routinely cleaned or replaced.
5. Rooms are not recleaned before admission, regardless of how long they are left empty.
6. Infections occur in many rooms, not any one in particular.

Recommendations of the Utilization Review Committee

1. Develop a written procedure for cleaning patient rooms.
2. Hold an inservice training program for housekeeping regarding the proper methods of cleaning rooms and its importance in preventing the spread of infection.
3. Germicidal solution is to be used in cleaning patient rooms.
4. Develop procedures for cleaning and replacing housekeeping equipment, on a time schedule.
5. All rooms that are left empty for three or more days must be recleaned before a new admission.
6. Housekeeping must clean the rooms in preparation for expected evening admissions.

Follow-Up of Utilization Review Committee Recommendations

Purpose
To determine if recommendations made by the Utilization Review Committee are being carried out.

Personnel Initiating Study
Administrator
Director of Nursing
Medical Director

Time Period
July—December, 1975

Population
All recommendations made by the Utilization Review Committee

Criteria
1. Date of recommendation
2. Type of recommendation
3. Was the Administrator advised of the committee's recommendation?
4. Was the recommendation carried out?
5. Date the recommendation was put into effect.
6. The reason the recommendation was not carried out.

Findings
1. There was usually a lapse of 2 to 3 months between the time the Utilization Review Committee made a recommendation and the time it was initiated by the administrative or nursing staff. Most of the recommendations were initiated after a period of time.
2. Recommendations that were not put into effect were either being disputed by various departments or were forgotten.
3. In-service training programs were in the majority of recommendations made. Developing written procedures for use by nursing, dietary and administrative departments were also frequently recommended. Other recommendations included checking on patients before meals for need to be fed, or restlessness at visiting hours or bedtime.
4. The administrator or an administrative representative were present at every Utilization Review Committe meeting. They were not notified in writing of the recommendations although they received copies of the committee minutes that listed the recommendations.

Recommendations of the Utilization Review Committee
1. A dated memorandum listing recommendations made at each Utilization Review Committee meeting will be sent to the administrator within 24 hours of the meeting.

2. One Committee member will be assigned to check on the progress of the recommendations at regular intervals and report back to the Utilization Review Committee.
3. Assigned committee members will meet with the supervisors of the departments that disputed recommendations to discuss why the recommendations were made and to obtain the reasons for the disputation by the departments.

Suggested Medical Care Evaluation Studies

1. The use of nurses for non-nursing functions.
2. The effectiveness of bowel and bladder training.
3. The source of drugs and the effectiveness of delivery.
4. Do patient charts reflect "skilled nursing."
5. The direct source of patients (hospital, other Skilled Nursing Facility, home, etc.).
6. Post discharge destination and the use of home care programs.
7. The frequency of readmissions within two weeks of discharge.
8. The adequacy of policies and procedures for medications.
9. The appropriateness of visits by attending physicians.
10. The need for a bowel and bladder training program.
11. The effectiveness of in-service training programs.
12. Appropriateness of admissions.
13. Timeliness of diagnostic services.
14. Incident reports.
15. Most common diagnoses and the type and amount of skilled services required for treatment.
16. Care of the dying patient.
17. Drug study (amounts and possible interactions).
18. Relationship between patient billing and laboratory tests done. (Patient billed for six laboratory tests but patient record shows results of only five.)
19. Medications and the diet.
20. Weight loss of the patient.

Attachment No. 1

HOSPITAL UTILIZATION PROJECT
SKILLED NURSING FACILITY PROGRAM — ABSTRACT OF MEDICAL RECORD

72-RO-881

1. PROVIDER NUMBER: 0 7 9 6 1 2 (1–6)

2. MEDICAL RECORD NO.: 0 0 0 1 3 5 2 7 9 4 (7–16)

PATIENT DATA

3	BIRTH DATE		(17) MO. 0 4 DA. 2 3 YR. 8 4
4	SEX & RACE	1 WHITE MALE 2 WHITE FEMALE 3 BLACK MALE 4 BLACK FEMALE 5 OTHER MALE 6 OTHER FEMALE	(23) 2
5	LIVING ARRANGEMENTS	1 ALONE 2 WITH SPOUSE 3 W/RELATIVES 4 W/NON-RELATIVES 5 FOSTER HOME 6 INSTITUTION	(24) 3
6	PAYMENT STATUS	1 MEDICARE 2 MEDICAID 3 BLUE CROSS 4 COMMERCIAL 5 SELF-PAY 6 OTHER	(26) 1
7	ZIP CODE		(28) 1 5 2 1 6

HOSPITAL STAY DATA

8	HOSP. CODE		(31) 3 2 2 2
9	PRIMARY DIAGNOSIS	C.V.A. w/o hypertension	(38) 4 3 6 . 9
10	ADMISSION DATE		(38) MO. 0 5 DA. 2 3 YR. 7 3
11	DISCHARGE DATE		(48) MO. 0 6 DA. 1 3 YR. 7 3

S.N.F. - DISCHARGE DATA

12	ADMISSION DATE		(51) MO. 0 6 DA. 1 3 YR. 7 3
13	DISCHARGE DATE		(57) MO. 0 8 DA. 0 7 YR. 7 3
14	ATTEND. PHYSICIAN		(63) 1 8 3 0 9
15	PHYSICIAN VISITS	1 MONTHLY 2 BI-MONTHLY 3 WEEKLY 4 DAILY 5 INFREQUENTLY 6 NEVER	(68) 2
16	DISCHARGE STATUS	1 WELL 2 MAX. REHAB. 3 PART. REHAB. 4 STATIONARY 5 DETERIORATING 6 EXPIRED	(69) 6
17	TRANSFER DESTINATION	1 HOME 2 FOSTER HOME 3 ORG. HOME CARE 4 CONTINUED SNF 5 GENERAL HOSP. 6 CUSTODIAL CARE 7 REHAB CENTER 8 PSYCH. FACILITY 9 COUNTY HOME 0 OTHER	(70)
18	CAUSE OF DEATH	AS SHOWN ON DEATH CERTIFICATE: C.V.A. w/o hypertension	(71) 4 3 6 . 9

S.N.F. MEDICAL DATA

19	MOBILITY STATUS	1 AMBULATORY W/O ASSIST. 2 AMBULATORY W/ASSIST. 3 CANE, CRUTCH, ETC. 4 WHEELCHAIR/SELF 5 WHEELCHAIR/PUSH 6 BEDFAST	(75)	ADM 5	(78) DISC 0
20	MENTAL STATUS	1 CLEAR 2 OCCAS. DISORIENTED 3 DISORIENTED 4 APHASIC 5 UNKNOWN	(77)	ADM 1	(79) DISC 0
21	BOWEL & BLADDER	1 CONTINENT 2 OCC. INCONTINENT 3 INCONTINENT 4 CATHETER-HOSP. 5 CATHETER-S.N.F. 6 COLOSTOMY	(76)	ADM 1	(80) DISC 0
22	FREQ. OF PHYSICAL THERAPY	1 DAILY 2 2-3 X WEEKLY 3 WEEKLY 4 OCCASIONALLY 5 NONE	(81)	5	
23	RESULTS PHYSICAL THERAPY	1 NO IMPROVEMENT 2 MODERATE IMPROVE. 3 OPTIMAL 4 NOT COMPLETE 5 NONE	(82)	5	
24	DECUBITUS	1 UPON ADMISSION 2 DURING S.N.F. STAY	(83)	1	
25	PRIMARY DIAGNOSIS	C.V.A. w/o hypertension	(84)	4 3 6 . 9	
26	OTHER DIAG. A	Diabetes Mellitus	(88)	2 5 0 . 9	
	OTHER DIAG. B	Decubitus Ulcer	(92)	7 0 7 . 0	
	OTHER DIAG. C		(96)		
	OTHER DIAG. D		(100)		
27	SPECIAL MEDICATION	1 TRANQUILIZERS 2 HYPNOTICS 3 ANTIBIDTICS 4 CHEMOTHERAPY 5 VASODILATORS 6 ANTICOAGULANTS 7 NARCOTICS 8 INSULIN	(104)	8 3 5 1	
28	SPECIAL TREATMENT	1 DECUBITUS CARE 2 I.V./TUBE FEEDING 3 TRACHEOSTOMY CARE 4 SUCTIONING 5 INHALATION THERAPY 6 DRES./EXC. DECUBITUS 7 RESTRAINTS 8 SPEECH THERAPY	(108)	1 7 0 0	
29	LEVEL CARE REQ'D. ADM.	1 CUSTODIAL 2 GENERAL NURSING 3 SKILLED NURSING 4 SPEC. THERAPY (P.T./O.T.)	(112)	3	
30	SPECIAL REPORTS 1		(113)		
	SPECIAL REPORTS 2		(117)		

SSA-2311

SKILLED NURSING FACILITY PROGRAM

ABSTRACT OF MEDICAL RECORD — HOSPITAL UTILIZATION PROJECT

MCA STUDY NO.

CORE INFORMATION

1	[redacted]		
2	MEDICAL REC. NO.		
3	BIRTH DATE	MO. DA. YR.	
4	SEX & RACE	1. WN. MALE 2. WN. FEM. 3. EK. MALE 4. EK. FEM. 5. SPAN. MALE 6. SPAN. FEM. 7. ORIENT. MALE 8. ORIENT. FEM. 9. OTHER MALE 0. OTHER FEM.	
5	ZIP CODE		
6	PAYMENT STATUS	1. MEDICARE 2. BLUE CROSS 3. SELF PAY 4. COMMERCIAL 5. OTHER	PRIM SEC
7	PRIM. PAY DAYS	(IF LAST BLOCK IF MEDICARE PAID SET 5 DATE ONLY)	PRIM DAYS (S)
8	HOSPITAL CODE		
9	HOSPITAL DISCHARGE DIAGNOSIS	PRIMARY / SECONDARY/PROCEDURE	

		ADMISSION MO. DA. YR.	DISCHARGE MO. DA. YR.
10	HOSPITAL		
11	S.N.F.		
12	PRIMARY S.N.F. DX.		
13	OTHER S.N.F. DIAGNOSES	A / E / C / D	
14	CAUSE OF DEATH	(AS INDICATED ON DEATH CERTIFICATE)	
15	ATTENO. PHYSICIAN		
16	DISCHARGE STATUS	1. DISCHARGED 2. TRANSFERRED 3. EXPIRED	
17	TRANSFER DESTINATION	1. HOSPITAL 2. S.N.F. 3. I.C.F. 4. REHAB. 5. PSYCH. FAC. 6. COUNTY HOME 7. HOME CARE 8. FOSTER HOME 9. BOARDING 0. OTHER	
18	SPECIAL REPORTS		

PATIENT CHARACTERISTICS

			ADM	STAY	DISC
19	MOBILITY STATUS	1. COMP. W/O ASST. 2. COMP. W/ASST. 3. CANE, CRUTCH, WALKER 4. WHEELCHAIR/SELF 5. BEDFAST 9. EXPIRED			
20	MENTAL STATUS	1. CLEAR 2. OCC. DISORIENTED 3. DISORIENTED 4. APHASIC 5. COMATOSE 8. LANGUAGE BARRIER 9. EXPIRED			
21	DIET	1. REGULAR 2. SPECIAL 8. GTUBE 9. EXPIRED			
22	FEEDING	1. SELF 2. PEED 3. PARTIAL HELP 4. GTUBE 5. EXPIRED			
23	BLADDER CONTROL	1. CONTINENT 2. OCC. INCONTINENT 3. INCONTINENT 4. CATHETER 5. UROSTOMY 9. EXPIRED			
24	BOWEL CONTROL	1. VOLUNTARY 2. OCC. INVOLUNTARY 3. INVOLUNTARY 4. COLOSTOMY 8. NONE 9. EXPIRED			
25	VITAL SIGNS	1. STABLE 2. UNSTABLE 9. EXPIRED			
26	RESTRAINTS REQUIRED	1. YES 2. NO 9. EXPIRED			
27	DECUBITUS	1. YES 2. NO 9. EXPIRED			
28	LOCATION OF DECUBITUS	LOCATION NO. 1 NO. 2 NO. 3 NO. 4			
29	FREQ. OF PHYSICAL THERAPY	1. DAILY 2. 2-5X WEEKLY 3. WEEKLY 5. OCCASIONALLY 8. NONE 9. EXPIRED			
30	RESULTS OF PHYSICAL THERAPY	1. NO IMPROVEMENT 2. MODERATE IMPROVE. 3. OPTIMAL 5. PLATEAUED 6. DISCONTINUED 8. HOME 9. EXPIRED			
31	SENSORY STATUS	1. BLIND 2. DEAF 3. BOTH 4. NEITHER 9. EXPIRED			
32	CONSULTATIONS	1. M.D. 2. PSYCHIATRY 3. PODIATEST 4. OPHYIST 5. PHY. THER. 6. SPCH. THER. 7. OCC. THER. 8. SOC. SER. 9. HOME			
33	LIVING ARRANGE.	1. ALONE 2. W/SPOUSE 3. W/REL. 4. FOSTER HOME 6. W/NON-REL. 8. INSTITUTION			
34	CONCURRENT REVIEW SECTION	ADMISSION 1. CERT'D 2. NOT CERT'D; L.O.S. ASSIGNED 1. INT. 2. EXT.; EXTENSION 0. NO. 1. RSN 2. OFF'D; PROG CODE; PHY ADV; DX CHG			

35. SPECIAL MEDICATIONS

		ADM	STAY	DISC
A	ANALGESIC (NON-NARCOTIC)			
B	ANTIBIOTICS			
C	ANTICOAGULANTS			
D	ARTHRITIS [illegible]			
E	CARDIAC DRUGS			
F	CHEMOTHERAPY			
G	DIURETICS			
H	INSULIN			
I	NARCOTICS			
J	SEDATIVES			
K	TRANQUILIZERS			
L	OTHER			
M	NONE			

36. SPECIAL TREATMENTS

		ADM	STAY	DISC
A	B/E TRAINING			
E	CATHETER CARE			
C	COLOSTOMY CARE			
D	DECUBITUS CARE			
E	DRESSING, OTHER THAN DECUBITUS			
F	INHALATION THERAPT			
G	IV/TUBE FEEDING			
H	MULTIPLE INJECTIONS			
I	REALITY ORIENTATION			
J	SPEECH THERAPY			
K	SUCTIONING			
L	TRACHEOSTOMY CARE			
[redacted]				
N	OTHER			

37. COMMENTS & NOTES:

EXAMPLE OF A TALLY SHEET

FALLS IN THE FACILITY

Patient Med.Rec Number	Date of Fall	Time of Fall AM/PM	Shift	Place of Fall Unit	Place	Ambulatory Status of Patient	Mental Status	Restraints Yes	No	Age	Primary Diagnosis	Attending Physician	Tranquil-izers Yes	No	Status of Floors
0395	01/03/74	4:20 PM	3-11	1 Main	Pt's Rm.	Walker	Alert		X	74	Fracture Right Hip	Dr. Duffin	X		Carpeted
1703	01/17/74	6:20 PM	3-11	1 Main	Pt's Rm.	Walker	Alert		X	66	A.S.H.D.	Dr. McKee	X		Carpeted
1715	01/09/74	4:20 PM	3-11	1 Main	Bathroom	Wheelchair	Alert		X	74	Myocardial Infarction	Dr. Jones	X		Carpeted
1714	01/12/74	9:10 AM	7-3	3 Resid	Hallway	Cane	Alert		X	80	Chronic Renal Disease	Dr. Jones	X		Carpeted
1716	01/14/74	10;55 PM	3-11	2 Main	Pt's Rm.	Cane	Confused		X	69	Chronic Bronchitis	Dr. Hall	X		Carpeted
0562	01/15/74	4:50 PM	3-11	2 Main	Pt's Rm.	Ambulatory	Intoxicated		X	72	A.S.H.D.	Dr. Carter	X		Carpeted
0324	01/21/74	7:15 PM	3-11	1 Main	Bathroom	Walker	Confused		X	82	Fracture Left Hip	Dr. Smith	X		Carpeted
9741	01/25/74	9:30 AM	7-3	1 Main	Pt's Rm.	Ambulatory	Alert		X	83	Anemia	Dr. Goldberg	X		Carpeted
2520	01/27/74	4:00 PM	3-11	2 Resid	Dining Rm.	Ambulatory	Alert		X	87	Emphysema	Dr. Fiasca	X		Carpeted
1482	01/30/74	8:00 AM	7-3	3 Main	Pt's Rm.	Walker	Fairly Alert		X	86	Diabetes	Dr. Benedict	X		Carpeted
3928	02/07/74	5:30 PM	3-11	2 Resid	Hallway	Ambulatory	Alert		X	80	A.S.H.D.	Dr. Bock	X		Carpeted
6989	02/18/74	5:00 PM	3-11	1 Main	Bathroom	Ambulatory	Confused		X	79	Chronic Brain Syndrome	Dr. Duffin	X		Carpeted
8398	02/21/74	6:05 PM	3-11	1 Main	Pt's Rm.	Wheelchair	Alert		X	67	Fracture Left Tibia	Dr. Hayes	X		Carpeted
3084	02/21/74	4:45 PM	3-11	3 Main	Pt's Rm.	Walker	Alert		X	74	Cataract	Dr. McFadyen	X		Carpeted
0680	02/28/74	11:20 PM	11-7	2 Main	Lounge	Ambulatory	Alert		X	85	Cataract Right Eye	Dr. O'Neil	X		Carpeted
1721	03/04/74	6:30 PM	3-11	1 Main	Pt's Rm.	Ambulatory	Intoxicated		X	78	Acute/Chronic Alcholism	Dr. Andrews	X		Carpeted
0573	03/12/74	5:45 PM	3-11	1 Main	Pt's Rm.	Wheelchair	Confused		X	88	Osteoporosis	Dr. Carter	X		Carpeted
0569	03/18/74	2:15 PM	3-11	1 Main	Pt's Rm.	Cane	Alert		X	72	Cerebral Vascular Acc't	Dr. Crowley	X		Carpeted
0126	03/24/74	1:15 AM	11-7	1 Main	Bathroom	Ambulatory	Alert		X	73	Congestive Heart Fail'r	Dr. Aloisio	X		Carpeted
0322	03/27/74	6:15 PM	3-11	1 Main	Pt's Rm.	Ambulatory	Alert		X	90	Diabetes	Dr. Rigby	X		Carpeted

Number of Nursing Personnel on Units:

1 Main	R.N., L.P.N., 4 Aides, Orderly
2 Main	" " " "
3 Main	" " " "
2 Resid	R.N., L.P.N., or Aide
3 Resid	" " "

Number of Patients on Each Unit:

1 Main	34 - 40 Patients
2 Main	" "
3 Main	" "
2 Resid	16 - 20 Patients
3 Resid	" "

Number of Bedridden Patients on Units: 8 out of 40

COMMENTS: _____

Attachment No. 4
Medical Care Evaluation Study
Falls

Patient Characteristics

Item	Number	Percent
Age		
65–69	3	15
70–74	6	30
75–79	2	10
80–84	4	20
85–89	4	20
90–94	1	5
95–99	—	—
Data Not Available	—	—
Ambulatory Status		
Wheelchair	3	15
Non Ambulatory	—	—
Ambulatory	9	45
Walker	5	25
Cane	3	15
Mental Status		
Alert	13	65
Fairly Alert	1	5
Confused	4	20
Intoxicated	2	10

January-March, 1974

Attachment No. 4 (*continued*)
Falls

General Information

Item	Number	Percent
Restraints		
Posey Belt	—	—
Waist	—	—
None	20	100
Data Not Available	—	—
Location (Floor)		
1 Main	12	60
2 Main	3	15
3 Main	2	10
1 Residential	—	—
2 Residential	2	10
3 Residential	1	5
Location (Place)		
Patient's Room	12	60
Bathroom	4	20
Hallway	2	10
Dining Room	1	5
Lounge	1	5

January-March, 1974

Falls

General Information

Item	Number	Percent
Time of Fall		
A.M. 12:01– 1:00	—	—
1:01– 2:00	1	5
2:01– 3:00	—	—
3:01– 4:00	—	—
4:01– 5:00	—	—
5:01– 6:00	—	—
6:01– 7:00	—	—
7:01– 8:00	1	5
8:01– 9:00	—	—
9:01–10:00	2	10
10:01–11:00	—	—
11:01–12:00	—	—
P.M. 12:01– 1:00	—	—
1:01– 2:00	—	—
2:01– 3:00	1	5
3:01– 4:00	1	5
**4:01– 5:00	5	25
5:01– 6:00	2	10
6:01– 7:00	4	20
7:01– 8:00	1	5
8:01– 9:00	—	—
9:01–10:00	—	—
10:01–11:00	1	5
11:01–12:00	1	5

**Happy Hour

January-March, 1974

Attachment No. 4 (*continued*)

Falls

General Information

Item	Number	Percent
Month		
January	10	50
February	5	25
March	5	25
Tranquilizers		
Yes	20	100
No	—	—
Status of Floors		
Carpeted	20	100
tear	—	—
uneven	—	—
Uncarpeted	—	—
slippery	—	—
water spill	—	—
Object on Floor	—	—

January-March, 1974

Attachment No. 4 (*continued*)

Attachment No. 5

Nurse's Admission Record

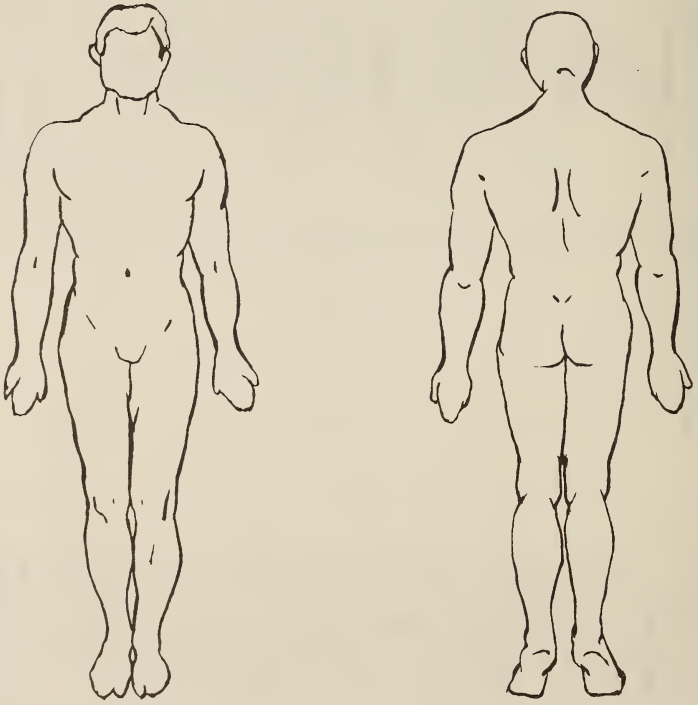
(To be completed by the nurse admitting the patient)

Family Name	First Name	Nursing Unit	Room No.

Attending Physician

Date

Indicate on the diagram below all body marks such as scars, bruises or discolorations (regardless of how slight), lacerations, decubitus ulcers and other ulcerations or questionable markings considered other than normal.



Signature of Admitting Nurse

ATTACHMENT #6 -A

SPECIAL REPORT

FACILITY NAME _____

REPORT TITLE Adequacy of Transfer Information

TIME PERIOD _____

PART I

ITEM	NUMBER	PERCENT
TRANSFERRING HOSPITAL		
REFERRING PHYSICIAN		

SPECIAL REPORT

(Adequacy of Transfer Information)

FACILITY NAME _____

PART II

ITEM	NUMBER	PERCENT
WERE PATIENT'S DIAGNOSES LISTED ON TRANSFER ? Yes No Incomplete Unknown Data Not Available		
WAS SPECIFIC MEOICAL INFO. LISTED ? Yes No Incomplete Unknown Data Not Available		
WAS PATIENT'S DIET LISTED ON TRANSFER ? Yes No Incomplete Unknown Data Not Available		
PATIENT'S MEDICATIONS LISTEO ON TRANSFER ? Yes No Incomplete Unknown Data Not Available		
WERE PHYSICIAN'S ORDERS FOR IMMEDIATE TREATMENT LISTEO ON TRANSFER ? Yes No Incomplete Unknown Oata Not Available		

Attachment No. 6-A (cont.)

ATTACHMENT #6-A (cont.)

SPECIAL REPORT
(Adequacy of Transfer Information)

FACILITY NAME _____

PART III

ITEM	NUMBER	PERCENT
WERE RELEVANT PATIENT PROBLEMS LISTED ON TRANSFER ? Yes No Incomplete Unknown Data Not Available		
HOSPITAL PERSONNEL RESPONSIBLE FOR TRANSFER INFORMATION Floor Nurse (RN-LPN) Medical Records Social Worker Attending Physician Other Unknown Data Not Available		

SPECIAL REPORT

FACILITY NAME _____

REPORT TITLE Admission Procedure

TIME PERIOD _____

PAGE I

ITEM	NUMBER	PERCENT
BASIC TRANSFER INFORMATION RECEIVED: Diagnoses Yes No D.N.A.		
Medications Yes No D.N.A.		
Diet Yes No D.N.A.		
Other Therapy Yes No D.N.A.		
Specific Medical Information Yes No D.N.A.		
Physician's Order for Immediate Transfer Yes No D.N.A.		
WAS ADMISSION SUPERVISED BY A REGISTERED NURSE Yes No D.N.A.		

SPECIAL REPORT

FACILITY NAME _____

(Admission Procedure - Continued)

PAGE II

ITEM	NUMBER	PERCENT
HISTORY AND PHYSICAL EXAM: Available on Admission Yes No D.N.A.		
Facility Physician will do Yes No D.N.A.		
ADMISSION QUESTIONS ANSWERED BY: Patient Yes No D.N.A.		
Representative Yes No D.N.A.		
WAS UNIT ORIENTATION GIVEN: Yes No D.N.A.		
WHO WAS CONTACTED FOR STANDING ORDERS: Referring Physician Yes No D.N.A.		
S.N.F. Attending Physician Yes No D.N.A.		

SPECIAL REPORT FACILITY NAME _____

(Admission Procedure - Continued)

PAGE III

ITEM	NUMBER	PERCENT
IF INADEQUATE TRANSFER INFORMATION WAS A PHYSICIAN AVAILABLE FOR: Medication Orders Yes No D.N.A.		
Diet Orders Yes No D.N.A.		
GENERAL WRITTEN ORDERS GIVEN TO FLOOR NURSE ON ADMISSION: Yes No D.N.A.		
WERE AIDES FAMILIAR WITH ROLE IN: Admission Procedures Yes No D.N.A.		
Patient Observation Yes No D.N.A.		
DID R.N. CHECK SKIN FOR: Decubiti Yes No D.N.A.		
Scars Yes No D.N.A.		
Reddened Areas Yes No D.N.A.		

ATTACHMENT #6-B (cont.)

SPECIAL REPORT FACILITY NAME _____

(Admission Procedure - Continued)

PAGE IV

ITEM	NUMBER	PERCENT
WERE COMPLETE NURSE'S NOTES WRITTEN NO LATER THAN THE END OF THE SHIFT WHEN PATIENT WAS ADMITTED: Yes No D.N.A.		
WAS A PRE-ASSEMBLED CHART AVAILABLE: Yes No D.N.A.		
DID THE PATIENT'S UNIT HAVE THE NECESSARY EQUIPMENT: Yes No D.N.A.		
WAS A RECORD KEPT OF PATIENT'S: Valuables Yes No D.N.A.		
Personal Effects Yes No D.N.A.		

ATTACHMENT #6-C

FACILITY NAME _____

SPECIAL REPORT

REPORT TITLE Evaluation of Nursing Admission Notes

TIME PERIOD _____

PART I

ITEM	NUMBER	PERCENT
ADMISSION INFORMATION: Collected by L.P.N. Yes No D.N.A.		
Verified by R.N. Yes No D.N.A.		
WAS THE PATIENT REVIEWED BY AN R.N. ON ADMISSION: Yes No D.N.A.		
WHO WROTE NURSES' NOTES: R.N. L.P.N. Aide Other D.N.A.		
WERE THE FOLLOWING INCLUDED IN ADMISSION NOTES: Date of Admission Yes No D.N.A.		
Time of Admission Yes No D.N.A.		

SPECIAL REPORT

FACILITY NAME _____

(Evaluation of Nursing Admission Notes)

PART II

ITEM	NUMBER	PERCENT
ADMISSION NOTES CONTINUED: Age Yes No D.N.A.		
Marital Status Yes No D.N.A.		
Race Yes No D.N.A.		
Sex Yes No D.N.A.		
Method/mode of Admission Yes No D.N.A.		
Where Patient was Admitted From Yes No D.N.A.		
Person Accompanying Patient Yes No D.N.A.		
Reason for Admission Yes No D.N.A.		
Mobility Status Yes No D.N.A.		

SPECIAL REPORT FACILITY NAME _____

(Evaluation of Nursing Admission Notes)
PART III

ITEM	NUMBER	PERCENT
ADMISSION NOTES CONTINUED:		
Admitting Physician Yes No D.N.A.		
S.N.F. Attending Physician Yes No D.N.A.		
Mental Status Yes No D.N.A.		
Reaction to Admission Yes No D.N.A.		
Vital Signs Yes No D.N.A.		
Body Audit Yes No D.N.A.		
Permanent Physical Disabilities Yes No D.N.A.		
Prosthesis Needed Yes No D.N.A.		
Known Allergies Yes No D.N.A.		

ATTACHMENT #6-C (cont.)

SPECIAL REPORT FACILITY NAME _____

(Evaluation of Nursing Admission Notes)
PAGE IV

ITEM	NUMBER	PERCENT
ADMISSION NOTES CONTINUED:		
Medication History Yes No D.N.A.		
Eating Habits Yes No D.N.A.		
Sleeping Habits Yes No D.N.A.		
Limited Social History Yes No D.N.A.		
Time Physician was Notified Yes No D.N.A.		
Response of Phy. when Notified Yes No D.N.A.		
Disposition of Personal Items Accompanying Patient Yes No D.N.A.		
Signature of Individual Preparing Disposition of Personal Items Yes No D.N.A.		

ATTACHMENT #6-D

SPECIAL REPORT

FACILITY NAME _____

REPORT TITLE Completeness of Patient Care Plan

TIME PERIOD _____

PART I

I T E M	NUMBER	PERCENT
INFO.INCL.ON PT. CARE PLAN		
Patient Activities		
Yes		
No		
Data Not Available		
Special Needs		
Yes		
No		
Data Not Available		
Hygiene		
Yes		
No		
Data Not Available		
Diet		
Yes		
No		
Data Not Available		
Feeding Problems		
Yes		
No		
Data Not Available		
Fluid Needs		
Yes		
No		
Data Not Available		
Bowel & Bladder Control		
Yes		
No		
Data Not Available		
Allergies		
Yes		
No		
Data Not Available		

SPECIAL REPORT

(Completeness of Patient Care Plan)

FACILITY NAME _____

PART II

I T E M	NUMBER	PERCENT
INFO. INCL.ON PT.CARE PLAN (cont.)		
Physical Traits		
Yes		
No		
Data Not Available		
Medications		
Yes		
No		
Data Not Available		
Short Term Goals		
Yes		
No		
Data Not Available		
Long Term Goals		
Yes		
No		
Data Not Available		
Patient Problems		
Yes		
No		
Data Not Available		
Nursing Approaches & Solutions (prob)		
Yes		
No		
Data Not Available		
Religion		
Yes		
No		
Data Not Available		
Occupation		
Yes		
No		
Data Not Available		
Admission Date		
Yes		
No		
Data Not Available		

Attachment No. 6-D (cont.)

ATTACHMENT #6_D (cont.)

SPECIAL REPORT

FACILITY NAME _____

(Completeness of Patient Care Plan)

PART III

I T E M	NUMBER	PERCENT
INFO. INCL. ON PT. CARE PLAN (cont) Diagnosis Yes No Data Not Available		
Physician Yes No Data Not Available		
Age Yes No Data Not Available		
Mental Status Yes No Data Not Available		
WAS THERE A PT CARE PLAN Yes No Data Not Available		
WHO INITIALLY FORMULATED & UPDATED THE PATIENT CARE PLAN Physician R.N. L.P.N. Medical Secretary Social Worker Other Data Not Available		
WAS INFO KEPT UP TO DATE Yes No Data Not Available		

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